Social Marketing RFA Background Information: 01/14/04

I. RFA TITLE

Better Health for Zambians Through Social Marketing ("Social Marketing Program")

II. BACKGROUND

The following provides background information on current Zambian Health issues and the USAID/Zambia Health program.

III. A. The Country Context

Since 1991, Zambia has undergone political transition from decades of one-party autocracy to multi-party democracy. Fundamental economic liberalization and structural reform programs have accompanied this political transformation. The political and economic development is constrained by its narrow economic base, historically dependent on copper mining, concentrated ownership of assets, limited foreign and domestic investment, and the legacy of centralized leadership, corruption and high unemployment.

The World Bank estimates Zambia's per capita Gross Domestic Product in 2001 at $350. External debt stood at $7.2 billion in December 2001, with debt servicing absorbing a fifth of the Government's budget revenue. The debt is owed primarily to multilateral institutions. In December 2000, Zambia was approved for debt relief under the Enhanced Debt Initiative for the Highly Indebted Poor Countries (HIPC). Zambia's debt stock is likely to remain unsustainable even with HIPC debt relief.

Zambia's social indicators remain very unfavorable due to the high disease burden, with life expectancy now under 40 years. The HIV/AIDS pandemic continues to ravage every sector of Zambia's economy, with productivity being under-cut by an unhealthy workforce, increased absenteeism, caring for the ill and attendance at funerals. The health system is rapidly becoming overwhelmed with the demands of this epidemic.

Zambia plays an important role in advancing U.S. national interests by contributing to greater stability and prosperity in the Southern African region. Zambia, a young democracy, has been a leader in open-market reform, plays a constructive role in regional efforts, and is making progress in curbing the spread of HIV/AIDS.

III. B. Health Sector Overview

III. B.1. Major health issues

While Zambia has seen some positive health trends in recent years, the picture is very mixed and still dominated by the specter of HIV/AIDS. The health problems that present development challenge include:

HIV/AIDS - HIV/AIDS remains an overwhelming development challenge in Zambia. Sixteen percent of Zambian adults are HIV positive. In urban areas, two in five women aged 25-39 are infected. Youth prevalence is much lower but the number of new cases of HIV among youth remains very high. Mother-to-child transmission also contributes significantly to disease burden. Currently, over 20,000 infants are newly infected each year. In addition to those infected, many others feel the impact of HIV/AIDS. By 2002, 15% of children under 15 had lost at least one parent due to AIDS. In the most recent

Demographic and Health Survey, 2001/2 (DHS), adult mortality was found to have increased by 17%, comparing the periods 1997-2002 to 1991-1996.

TB - Zambia has one of the highest case-notification rates in the Southern-African region and is in the midst of a serious TB epidemic that shows no signs that it is abating. This increase is most likely due to the impact of the HIV/AIDS epidemic and subsequent breakdown of TB services. The current TB incidence is estimated at approximately 500 cases per 100,000. The Ministry of Health (MOH) estimates that the number of new TB cases will continue to increase rapidly and reach at least 50,000 per year by 2005. The implementation of the Directly Observed Therapy, Short Course (DOTS) is currently a key priority.

Under-five mortality - Under-five mortality has dropped from 197/1000 in 1996 to 168/1000 in 2001/2. Malaria and HIV/AIDS, compounded by malnutrition, have been the two principal causes of death in this age group. There is speculation that the successful Vitamin A program in Zambia has contributed significantly to the decrease in under-five mortality, despite the high burden of malaria and HIV/AIDS.

Malaria – Malaria incidence has increased at least three-fold over the past two decades and is currently the leading cause of death among children in Zambia, and a major direct and underlying cause of death among adults. The Ministry of Health estimates that, from a population of just over 10 million there are more than 3.5 million malaria clinic out-patient visits and 50,000 deaths per year.

However, the Government's malaria control program is one of the most successful and well-led national programs. In response to the global Roll Back Malaria Initiative, the public and private sectors have collaborated on substantially increasing the availability of subsidized and unsubsidized treated bednets.

Malnutrition – Stunting, found throughout Zambia, has continued to increase and now affects about half of children under-five (47%, up from 40% in 1992). Rates are especially high in northeastern Zambia, where 55% or more of children under-five are stunted. Although mean height for Zambian women is close to average for sub-Saharan Africa, the proportion that are thin are higher than average. Anemia is widespread with 65% of children and 39% of non-pregnant women found to be anemic. Poverty, food insecurity due to HIV/AIDS, unfavorable agricultural policy and production factors, dietary and child feeding practices and disease appear to be the most important factors contributing to malnutrition in Zambia.

Maternal Mortality – Maternal mortality increased from 649/100,000 live births in 1996 to 729/100,000 in 2001/02. Although the vast majority of Zambian women, 93% of pregnant women, receive some antenatal care, the quality is poor and many interventions are not delivered. Most deliveries are not attended by a medically trained health professional and emergency obstetric care is not widely available, especially in rural areas. Lack of access to such care, limited MCH outreach services and the scarcity of post abortion care services also contribute to the high maternal mortality rate.

Sexually Transmitted Infections (STI) - The 2000 Health Facilities Survey found that sexually transmitted infections (STIs) are a common and serious public health problem in Zambia. Despite the fact that STIs account for 10% of out patient care and 10-15% of ANC attendees test positive for syphilis, health clinic attendees are continually receiving

inadequate care. Many patients attending health clinical care facilities for STI treatment are not receiving appropriate case management and are not being provided with appropriate drugs due to stock outages of the drugs.

Family Planning: While family planning and use of modern contraceptive methods have become more widespread, the total fertility rate (TFR) remains high and has declined only slightly to 5.9 live births per woman in 2001/2 compared with 6.1 in 1996. The overall contraceptive prevalence rate (CPR) for modern methods is 23% (urban 39%, rural 14%). Of the methods available in Zambia, (oral contraceptives, IUD, injectables - Depo-Provera and Noristerat, implants, diaphragm and male/female condoms), oral contraceptive pills continue to be most popular method of contraception. Most young people, especially those unmarried, have little or no access to family planning services or interventions.

DHS data show that 27% of adults of reproductive age have unmet need for family planning, the same proportion as in 1996, and that the unmet need for birth spacing is greater than the unmet need for limiting the number of children -17% and 11%, respectively. Rural women have a higher unmet need for family planning - 29% - than urban women -26%, and there are wide provincial disparities in unmet need, which is highest in the Southern and Central Provinces.

III.B.2. The National Health Strategic Plan, 2001 -2005 (NHSP) and the Sector-Wide Approach

The National Health Strategic Plan, 2001 – 2005 (NHSP) provides the framework for the government's health program and for cooperating partner assistance to the sector, including that of USAID. The vision of the NHSP is "to provide Zambians with equity of access to cost-effective quality health care as close to the family as possible." Areas of focus of the NHSP include: public health priorities (including malaria, HIV/AIDS, integrated reproductive health and child health); a sector-wide approach; improving access to clinical care; the district as key intervention level; gender and health; hospital-sector reform; health care financing; and support functions (including human resources, drugs and infrastructure).

The government is committed to a "Sector-Wide Approach" (SWAp) actively involving bilateral and multilateral partners in collective planning and oversight of the sector. Central to the SWAp concept is the government's desire that cooperating partner support be provided directly through pooled funding arrangements which provide resources for district health services and hospitals. There are plans to soon expand these arrangements to include drugs, human resources and other areas. Many cooperating partners contribute to the pooled funding and several provide the bulk of their health sector support in this manner. A few, including USAID, continue to provide most of their support directly to program activities.

As part of the implementation of the health reform, the Government of Zambia has made the semi-autonomous body, the Central Board of Health (CBOH), responsible for implementing health services and devolving significant decision-making authority to the District Health Management Teams (DHMTs) and their local health boards, District Health Boards, (DHBs). Provincial Health Offices (PHOs) are part of the CBoH and

provide technical support to districts. Each provincial office is staffed with technical specialists and headed by a provincial director. At the community level, Neighborhood Health Committees (NHCs) are active in many areas, serving as an important link between formal health services and the populations they serve.

III.C. USAID/Zambia Support to the Health Sector - 1998-2003

USAID/Zambia's prior Country Strategic Plan (CSP) (1998-2003) had four Strategic Objectives in the areas of agricultural and private sector (SO1), education (SO2), population, health and nutrition (SO3) and democracy and governance (SO4).

USAID/Zambia's Population, Health and Nutrition (PHN) program was aimed at ensuring "increased use of child health, reproductive health and HIV/AIDS interventions". To this end, its strategic approach was comprised of five activity areas: (1) demand creation; (2) development of community partnerships; (3) development of private sector partnerships; (4) improved performance of the health care system; and (5) support of policy and systems strengthening. Through FY 2003, these activities were carried out primarily under SO3, geared to support improved primary health care in the decentralized GRZ system. The overall technical focus of the USAID PHN program was HIV/AIDS, child health and nutrition, malaria, reproductive health and safe motherhood.

Activities were planned and implemented in close partnership with the GRZ's national bodies, PHOs, DHMTs, the private sector and non-governmental (NGO) and faith-based organizations. Taking all sectors into account, USAID/Zambia supported health activities in all of Zambia's nine provinces. At the central level, USAID/Zambia participated actively in several national Technical Working Groups (TWGs), including those on STI, IEC, Reproductive Health, PMTCT, VCT and Care and Health Care Financing.

Bilateral Support .- USAID/Zambia's major bilateral activities within its PHN program included (1) Social Marketing; (2) Behavior Change Communications; (3) Health Services Strengthening; (4) Health Systems Development and (5) Provision of Health Services to Underserved/Hard to Reach Areas. Four of USAID/Zambia's bilateral implementing partners primarily provided support at the central level (MOH/CBOH) for national activities, while also targeting 12 "demonstration districts". A fifth partner sub-granted to four faith-based NGOs to provide community-based primary health care services to underserved areas in four districts.

Central Funding - A large portion of the Mission's support was programmed through centrally-funded mechanisms. These programs complemented the bilateral programs by providing specialized technical assistance and program implementation in key areas such as child survival, HIV/AIDS prevention and service delivery, drug management and logistics, safe motherhood, reproductive health and support for orphans and vulnerable children (OVCs).

Participation in the SWAP - In addition to the Mission's bilateral and centrally-funded programs, USAID/Zambia strongly supported the GRZ's sector-wide approach to health. USAID/Zambia's contribution to the "District Basket" of up to $2 million per year for health services at the district level and below was covered through a Sector Program

Assistance agreement (SPA) 1999-2004. Funds were released to the basket depending on the achievement of previously negotiated health sector performance targets.

III.D. USAID/Zambia's Country Strategic Plan - 2004-2010

USAID/Zambia's current Country Strategic Plan (CSP) (2004-2010) has five Strategic Objectives in the areas of agricultural and private sector (SO5), education (SO6), population, health and nutrition (SO7), democracy and governance (SO8) and multisectoral HIV/AIDS prevention and mitigation (SO9).

The new Strategic Objective (SO7), "Improved Health Status of Zambians", supports the GRZ's national health development strategy as described in the NHSP. SO7 is supporting the health sector through three Intermediate Results (IRs):

- IR 7.1, Zambians Taking Action for Health
- IR 7.2, Achievement & Maintenance of High Coverage for Key Health Interventions
- IR 7.3, Health Services Strengthened

III.E. Status of the Former Social Marketing Program

From 1992 through 2004, USAID has supported social marketing in Zambia through cooperative agreements that addressed HIV/AIDS/STIs, family planning, malaria prevention and water purification to prevent diarrheal disease. The implementing agency established a local affiliate, the Society for Family Health (SFH), a non-governmental social marketing organization. SFH activities have included development and dissemination of health and family planning information, messages and advertising, with an emphasis on product promotion and promotion of disease prevention and family planning methods.

The program's product advertising and messages on methods have been disseminated using a variety of conventional print, mass media and non-traditional media. Sales of socially-marketed products are made to wholesalers, who then resell the products to small retailers in Zambia's nine provinces. The program also distributes and sells its branded products through certain NGOs, the GRZ's district health management teams; other GRZ Ministries; retail outlets patronized by high-risk groups and the general population; and large private sector employers, such as companies like Coca Cola. Wholesalers, retailers and other agents retain portions of sales proceeds. The program has also:

- provided condoms through community-based distributors to high-risk groups in border towns through the Cross Border Initiative;
- collaborated closely with another ongoing USAID health communications implementing partner; and
- created demand for HIV voluntary counseling and testing (VCT) services as one of eight key partners supporting Zambia's VCT services through the GRZ's CBoH.

The former social marketing program has achieved notable successes. SFH is a prominent member of the development community, respected by public officials, private

sector organizations and for-profit businesses. The program has established an effective wholesale-to-retail distribution and transport network, a Lusaka central office and six provincial offices with technical, management and supervisory staff. There is some level of social marketing program activity in each of Zambia's nine provinces.

The program's implementing agency has successfully negotiated funding for SFH activities and commodities with other cooperating partners, supplementing USAID-provided resources and commodities. The program also sells products through DHMTs and NGOs, working at district level or below. The social marketing program and its branded products are well known in Zambia, particularly in urban areas. Sales of each product have generally risen over the program period, providing increased access to disease prevention and family planning through accessible sales outlets; complementing over-stretched public sector health facilities offering these necessary services.

III.E.1. Male Condoms - The former social marketing program's promotion and distribution of subsidized male condoms, under the brand name 'Maximum', was started in 1993 and targets high-risk groups and individuals like commercial sex workers and their clients – bus and truck drivers and other workers – and people within the general population at risk for HIV/AIDS/STIs.

From 1993 to 2002, Maximum annual sales increased from 4.7 to 9.6 million, although annual targets have not always been met. In 2002, temporary sales problems were experienced and promotional efforts flagged, much of this due to the illegal importation of a lower priced condom from a neighboring country. The target of 10.5 million was set for 2003.

DHS data has shown that condom use in Zambia has become much more widespread. As of 2003, the majority of condom users reported using condoms obtained through the social marketing program. Yet condom use for HIV/AIDS/STIs prevention among couples/partners in marriages or long-term monogamous relationships is still low in Zambia.

III.E.2. Oral Contraceptive Pills (OCPs) - In Zambia, OCPs are the most widely-used modern family planning method distributed in public sector facilities and targeted by the social marketing program for use by couples and long-term partners. In 1997 'SafePlan' was introduced and remains the only OCP offered through a social marketing program. According to the DHS, it has been estimated that SafePlan now amounts to about 15% of all OCPs used in Zambia. Sales rose from 182,000 units in 1997 against a target of 100,000 units in that year, to 491,000 units in 2002 against a target of 550,000 units in 2002. Until 2002, all prior year annual sales exceeded annual targets. This 2002 slowdown in sales is contributed somewhat to a change in marketing strategy, resulting from increasing concern over how to present this family planning method given the continued HIV/AIDS epidemic. With resumption of the marketing of SafePlan, the sales target for 2003 remains 550,000 units.

III.E.3. Insecticide Treated BedNets (ITNs) - The goal of the GRZ's malaria program is to ensure that 60% of those at risk of malaria, especially pregnant women and children under five, benefit from the most suitable combination of personal and community protective measures including ITNs. According to the DHS, 27% of households in Zambia own a mosquito net, with 14% owning an ITN and of those, only 5% having soaked or dipped their net at least once. Many adults in households do not use bednets correctly or consistently to protect either their children or themselves.

Numbers of ITNs sold by all sources in Zambia to prevent malaria have steadily increased over the past five years, although much remains to be done to increase coverage; encourage correct, continued use; and increase periodic retreatment. Treated bednets are available in Zambia through the public and commercial sectors which have collaborated, and are expected to continue their collaboration, to substantially increase the availability of subsidized and unsubsidized treated bednets.

USAID/Zambia, in partnership with JICA, launched a pilot study of branded ITNs for malaria prevention in 1998, marketing the ITNs to poor and highly vulnerable rural households. These sales of 'Powernet' rose to 25,000 units by 2002 and produced important findings on the future scaling-up of ITNs. This pilot project is now being phased out in favor of the current socially marketed ITN branded as 'MamaSafenite', introduced in 1997 and targeted to mothers through NGO supported antenatal and well-child clinics. This product sold 55,000 units in 2002, and will continue to be the subsidized ITN supported through USAID. In addition to 'MamaSafenite', late in 2001 two private commercial partners also launched the sale of unsubsidized ITNs through the retail market with assistance from the USAID-funded NetMark project, and sales rose to 185,000 in 2002, for a total of about 265,000 ITNs sold in 2002 with USAID support. As of August 2003, combined sales had risen to 300,000.

III.E.4. Bottled Water Purification Fluid - 'Clorin' is a point-of-use bottled fluid that is a water chlorination treatment for prevention of diarrheal diseases. Piloted in 1998, the marketing of Clorin began on a geographically-limited basis during the following year and distribution was quickly scaled up to meet the strong demand from consumers. Annual sales substantially exceeded annual targets. According to the DHS, 75% of households have heard of Clorin (65% in rural areas), an impressive accomplishment, however, use at the time of the survey was much lower, at 14% of all households and only 7% of rural households. Field trials conducted by the Centers for Disease Control (CDC) in Zambia showed a 30% reduction in diarrheal disease in households using Clorin, and the product appears to be increasingly used by consumers throughout the year and not only in the annual "cholera season".

Sales of Clorin rose from 3,558 units in 1998 to 1.l8 million units in 2002 against a target of 1.0 million set for that year. The target for 2003 was set at 1.3 million units. Similar to the marketing of ITNs, sales are expected to rise and it is anticipated that the full potential impact of this public health intervention will be realized.

III.E.5. Female Condom - The female condom, 'CARE' was introduced by the former social marketing program in 1997 with support through the German aid agency, KFW. CARE has been targeted for prevention of HIV/AIDS/STIs among high-risk women. A total of 668,000 units have been sold to date.

III.E.6. Multivitamin - 'Vibrant!', a multivitamin containing iron folate for pregnant and other anemic women was introduced by the former social marketing program in 2001.

Please refer to the Table below for trend data on sales of branded products promoted and distributed under the former social marketing program.

Product	2000	2001	2002	2003*)	Target 2003	2003 vs. 2002	2003 vs. Target
Maximum	8,365,716	9,959,760	10,106,496	11,745,925	11,500,000	16.2%	2.1%
care	68,112	115,368	253,128	243,680	350,000	-3.7%	-30.4%
New Start			8,156	7,636	7,200	-6.4%	6.1%
SafePlan	432,924	516,960	507,120	694,336	575,000	36.9%	20.8%
Clorin	561,291	1,014,504	1,166,760	1,758,584	1,300,000	50.7%	35.3%
Mama Safenite		11,902	55,402	164,388	145,000	196.7%	13.4%
Safenite	2,059	27,860	69,054	45,587	28,000	-34.0%	62.8%
PowerNet	57,279	42,227	29,433	20,000	20,000	-32.0%	0.0%
Vibrant		77,280	99,300	122,700	150,000	23.6%	-18.2%

*) 2003 figures are prorated on the basis of the first nine months. This is likely to underestimate the final sales figures since the last quarter sales normally exceed the annual average. 2003 for Powernet are based on an estimate of preliminary numbers that were obtained from the different health centers.

The program's implementing agency has over the life of the project conducted a number of research studies to help refine activity implementation:

2003 Kusanthan T, Muhwava W. **Changes in the Availability and Distribution of Socially Marketed Condom and Family Planning Products in Urban Zambia**, Research Department, Society for Family Health, Lusaka, Zambia.

2003 Kusanthan T, Muhwava W. **Survey on Availability and Distribution of Socially Marketed Health Products in Urban Zambia**, Research Department, Society for Family Health, Lusaka, Zambia.

2003 Rossem R.V. Agha S. Stallworthy G. Kusanthan T. **The Impact of an Insecticide Treated Net Intervention on Differentially Reaching the Poorest Individuals in Rural Zambia and on Increasing Equity in Knowledge, Beliefs and Behaviour Related to Malaria**

Prevention,Research Department, Society for Family Health, Lusaka, Zambia.

2003 Caroline Trigg**, HIV Risk and Nightclub-Based Sexual Workers in Lusaka**, Research Department, Society for Family Health, Lusaka, Zambia.

2003 Agha S. Kusanthan T. **Equity in Access to Condoms in Urban Zambia**, Health Policy and Planning, Vol. 18, No.3

2003 Rebecca Cramer, Kim Longfield and Sachingongu N. **Misconceptions, Folk Beliefs, and Denial: Young Men's Risk for STIs and HIV/AIDS in Zambia**., PSI Research Division.

2002 Agha, S. Kusanthan, T, Longfield, K. Klein M, Berman, J. **Reasons for Non-Use of Condoms in Eight Countries in Sub-Saharan Africa,** Research Department, Society for Family Health, Lusaka, Zambia.

2002 Kim Longfield, Megan Klein and John Berman, **Multi-Country Study on Trusted Partner and Youth: Eritrea, Tanzania, Zambia, and Zimbabwe,** Research Department, Society for Family Health, Lusaka, Zambia.

2002 **Nicholas Shiliya,** Knowledge, Attitudes and Practices about multivitamins among Females, **Research Department, Society for Family Health, Lusaka, Zambia.**

2002 Jean Tooley. **MAXIMUM Brand Positioning Qualitative Research Results,** Research Department, Society for Family Health, Lusaka, Zambia.

2002 Muhwava W, Kusanthan T. **Voluntary Counseling and Testing (VCT) Client Intake at New Start Centre in Lusaka, Zambia**, Research Department, Society for Family Health, Lusaka, Zambia.

2002 Muhwava W, Kusanthan T. and Sachingongu N. **Reproductive Health Issues and Condom Use Among Youths in Zambia: Findings from Round One of the Multi-Round Survey,** Research Department, Society for Family Health, Lusaka, Zambia.

2001 Sachingongu, N.. **Qualitative Research Study to Explore HIV Risk Perception Amongst Out of School Adolescent Boys in Lusaka, Zambia, and the Sources & Quality of Information Available to them,** Research Department, Society for Family Health, Lusaka, Zambia.

2001 Mwaba, C. Nchima. **Qualitative Research Study to Explore HIV Risk Perception Amongst Out of School Adolescent Girls in Lusaka, Zambia, and the Sources & Quality of Information Available to them,**

Research Department, Society for Family Health, Lusaka, Zambia. 2001.

2001 Agha S, and Mwaba C. **HIV Risk Among Street and Nightclub-Based Sex Workers in Lusaka, Zambia: Implications for HIV Prevention Interventions**, Working Paper No.38, PSI Research Division. 2001.

2001 Agha S. **An Evaluation of the Effectiveness of a Peer Sexual health Intervention Among Secondary School Students in Zambia**, Research Department, Society for Family, 2001.

2001 Kusanthan. T**. Attitudes Towards Water Quality and Water Use Practices in Zambia**, Research Department, Society for Family Health, Lusaka, Zambia. 2001.

1999 Chege N. and Agha S. **Attitudes towards water quality and water use practices in low income areas in Lusaka**, PSI Research Division, 1999.

2001 Wotela K.K **An Evaluation of the effectiveness of a water purification peer education prgramme in increasing knowledge and improving attitude**, Research Department, Society for Family Health, 2001.

2000 Kusanthan. T. Sachingongu N. **Malaria Prevention and Insecticide Treated Net Survey**, Research Department, Society for Family Health, Lusaka, Zambia. 2001.

2001 Agha S. Kusanthan T. **Equity in Access to Condom in Urban Zambia**, Working Paper No.32, Research Division, Population Services International, Washington, D.C. USA.

2000 Kusanthan. T. Suzuki KG. **Zambia Urban Sexual Behaviour and Condom Use Survey- 1999**, Research Department, Society for Family Health, Lusaka, Zambia. 2000

1999 Emmanuel D. Agha S, and Kusanthan T. **Zambia Social Marketing and Condom Availability Survey**, Research Department, Society for Family Health, Lusaka, Zambia.

1999 Agha, S. **Patterns of Use of the Female Condom in Lusaka, Zambia**, Working Paper No.25, PSI Research Division. 1999.

In order to ensure that USAID funded technical assistance and program support achieves the greatest impact, the Mission and all implementing partners agree that the following principles are guiding our activities in Zambia:

Principles of Conduct

1. We are here to support the implementation of the Zambian health reforms vision : access to cost effective and quality services, as close to the family as possible.

2. We strive to improve the existing services and systems and not to create parallel ones. We commit ourselves to listening to the needs of government and civil society and we try to respond to those needs.

3. We strive to ensure maximum ownership of the programs we initiate together with our institutional partners - be they public or private-, so that sustainable results and strengthened leadership are two of their key outcomes.

4. We will ensure that our Zambian partner institutions take the lead in calling meetings, in hosting disseminations, and in issuing reports.

5. We endorse the concept of advisors working in the background without need for visible recognition.

6. We pay special attention to the need for transparent information with regard to program costs to be given to our partner institutions.

7. We will be cost effective in the use of USAID funds so that Zambia will benefit maximally from our project resources.

8. We will spare no efforts in coordinating effectively amongst ourselves so that none of our interventions results in needless duplication.

9. We will continuously keep our focus on results and on impact so that our aid will have real impact on Zambian lives.

10. We will foster innovation, mindful of the different contexts that may call for stability or continuity, and we will expect innovative approaches to be cutting edge, primarily within the contexts in which they will be embedded. Our mistakes will be there to learn from, and not to be repeated.